Welcome to Spotlighting What Works, a new bulletin that will share information with you three times each month about the exemplary professional practices of HUD field office staff, grantees, and nonprofit organizations. Each issue will highlight one successful technical assistance, programmatic, management, or technological tool that could enhance your effectiveness in helping to improve the quality of life in America's low-income communities. This issue features a brief analysis of various approaches to Continuum of Care.
In sharing with you such examples of innovation and creativity among HUD staff, grantees, and others, we hope to foster the success of all community development activities by learning from and building upon the successes of others.

Continuum of Care in Action
Meeting the Challenges of Housing the Homeless in America

At A Glance . . .

Arundel Community Development Services, Inc., an independent nonprofit corporation in Maryland, and many other organizations like it throughout the country are helping to bridge the gap between the poor and the rich by ensuring equal access to basic community services. Strong partnerships formed with County, State, and local governments are creating opportunities for low-income residents to free themselves from the traps of poverty and exclusion.

This particular nonprofit took on the task of unifying County and State practitioners, residents, and elected officials to not only renovate, but preserve a historic African-American community that has survived since the 1800s without indoor plumbing. Added to that were a host of other housing renovations that needed to be completed to bring this small community "out of the 1880s and into the 1990s," according to one resident.

Their combined efforts, along with HOME and CDBG support, have done more than just enable the residents of Tenthouse Creek to finally draw water from inside faucets. They have demonstrated to the community that partnerships and place-based strategies work in producing quality affordable housing and that a community vision can be shared and realized by everyone's efforts.

Making A Difference, Giving Hope

Each hour of every day this country is faced with the challenge of combatting the problem of homelessness. Undeniably, the homeless population crosses all geographic, racial and age boundaries with each person having a distinct need for housing and supportive services. By no means, as many communities have found, is homelessness insurmountable. Urban, suburban and rural areas are boldly accepting the challenge and enlisting the support of HUD in their efforts to develop workable solutions. Their charge is to diminish the problem and give dignity to those who are in need of a place to call home. HUD recognized early on that localities and homeless providers need sufficient and flexible Federal resources to create a comprehensive and coordinated system that addresses the many dimensions of homelessness. That's why the administration dramatically increased the budget for HUD's homeless programs and as part of the application for its competitive programs, asked communities to design and submit a Continuum of Care strategy.

Just what constitutes a good Continuum of Care system? Where does one begin and how and with what? In September of 1996, HUD announced some $675 million in grants to fund projects in more than 265 communities providing housing and services to over 300,000 homeless people. Though there are many good examples to choose from, the examples represent different approaches that work for large metropolitan areas, medium-sized urban and suburban communities, and rural areas as part of state-wide efforts.

Community Process, Strategy, Gaps and Priorities, and Supplemental Resources are essential to a Continuum of Care strategy. A short analysis of the applications from Anchorage (AK), Metro Denver (CO), Lansing (MI), Harris County (TX), and the States of Idaho, Kentucky and Maryland along with some input from key local players helps illustrate each part.

Part 1: Your Community Process - Building Alliances

The community process is important to help build partnerships and coordination with states, localities, not-for-profit organizations, and the federal government; therefore, ensuring the development of a comprehensive approach to housing and service delivery. Denver, Colorado shows how a major metropolitan area began its community process.

Six counties in the State of Colorado joined to form the Metro Denver Homeless Initiative (MDHI). These six counties--Adams, Arapahoe, Boulder, Denver, Douglas, and Jefferson--include 28 cities. MDHI sought to coordinate interjurisdictional and interdisciplinary solutions with the active involvement of the community, including homeless persons. Early on, it developed a mission statement to identify and eliminate gaps in the current delivery system, reduce duplication, and unite the community with the goal of maximizing the independence of its consumers.

The early stages of MDHI's planning process started in March 1994 with initial meetings with the Colorado State HUD Office in Denver. These discussions triggered a symposium of 70 diverse organizations representing homeless and housing providers, local and state agencies, private foundations, mental health centers, neighborhood organizations, and homeless or formerly homeless individuals. Coordination with mainstream programs was encouraged by the Colorado State Departments of Human Services, Local Affairs, Education, and Labor and Employment. From this symposium, the elements of MDHI's system were formed and 30 representatives were elected to serve on a steering committee to coordinate further planning.

The Steering Committee and the Department of Local Affairs built on these efforts by submitting and receiving funding from the Innovative Cities Demonstration Program. In December 1996, as part of the initial kickoff for MDHI, a 125-member stakeholders community planning board was created. Every three weeks, an average of 65 people meet. The National Civic League facilitated the meetings and the stakeholders elected a 39- member inclusive and diverse Governance Board with sub-committees to represent their interests. The Board developed a mission statement and the process for involving stakeholders who identified seven Key Performance Areas (KPAs) which were further defined by task groups in such areas as computerized intake and assessment and case management. Further, MDHI developed a five point strategic plan for 1996-2000 that includes specific actions steps that will be taken, including achieving legal status.

Urban areas are not the only places affected by homelessness. The State of Kentucky, with more than 100 mostly rural counties, faced many of the same challenges of Metro Denver in its community process, however, because the Commonwealth is mostly rural it had to overcome the physical distance between partners in the process and the pure vastness of the area covered. Additionally, it had fewer formalized networks, infrastructure and community amenities, and fewer homeless providers.

According to Natalie Hutcheson, Homeless Programs Administrator, it may be a simple process when participants are located in the same area and can meet an hour or two for lunch. It is a different scenario when meeting regionally and participants must travel for three hours or so in order to meet.

In order to start a community process covering 118 counties (excluding the urban centers of Lexington and Louisville), the Commonwealth first had to gain information on the extent of homelessness within its boundaries and on the needs of homeless persons.

In 1994, the Kentucky Housing Corporation (KHC) held meetings throughout the Commonwealth with housing and service providers, homeless advocates, homeless persons, and other organizations. From those meetings, a statewide resource manual of available services was developed and, from this inventory, service gaps were identified. Additionally, a statewide survey on homelessness was administered.

To gain more citizen input, KHC held six hearings across the Commonwealth in conjunction with the citizen participation meetings held for the Kentucky Consolidated Plan. A questionnaire was sent to those unable to attend.

The distance issue raises another series of problems for low-income persons who must travel. Transportation and day care then become major hurdles for the less affluent. Hutcheson has arranged to get outside training on how to address this problem and ensure that low income persons remain a significant part of the process.

Having learned from the Consolidated Plan process that planning statewide was not practicable or reliable in reflecting regional differences within the state, all 118 counties were clustered based on regional similarities into 15 area development districts. This approach worked well for the development of their Continuum of Care process since most homeless service providers, including community mental health centers, community action agencies and domestic violence centers, were already organized to serve specific geographic areas. Turf issues were initial challenges to the Kentucky process, according to Hutcheson. There were concerns among the participants about the competition for funding.

Hutcheson knows the process well. She advises applicants to begin the process early. Deadlines must be met no matter what may be occurring locally, nationally, or globally. With Kentucky, the Federal government shutdown impacted significantly on their time schedule. The time frame to meet each milestone should allow for potential setbacks or obstacles. The process should allow for some flexibility.

Hutcheson feels that as long as the process stays relatively the same, Kentucky will be able to improve upon their future applications. They have a good handle on what needs to be done and how to do it.

Helpful Hint . . .

Teamwork Counts. Develop a broad representation of participants or team players. Avoid turf disputes and competition within team. Teamwork Counts. Develop a broad representation of participants or team players. Avoid turf disputes and competition within team.

In January 1996, KHC co-sponsored a kick-off conference with the Kentucky State HUD Office to develop goals for the next steps in KHC's planning process. The following month, KHC held meetings in each of the 15 districts to establish a local Continuum of Care Planning Board. Each board consists of representatives of all sub-populations for each of the counties in the district, including homeless service providers, homeless and formerly homeless persons, business and civic leaders, governmental entities, homeless advocates and other organizations.

The Boards added the missing infrastructure that was needed for real local input and provided a mechanism to fund long neglected rural areas. Additional meetings were held to select a primary representative from each of the 15 districts to the state Continuum of Care Planning Board and to develop a local inventory of available resources and to identify gaps and establish local priorities. The state board serves as a second filter for screening applications for homeless assistance funding and as an administrative and evaluation body.

Lessons Learned - The Process

What can be learned from Metro Denver and the State of Kentucky, two very different places? Here's five essential ingredients to planning for a Continuum of Care:

Formal Structure - A good system necessitates an inclusive coordinating council or network. Develop a structure that allows broad participation as well focused expertise in specific tasks.

Mission, Goals and Action Steps - Be specific and concrete. Focus your energy and minimize getting off-track. Build in rewards and time to reflect on progress.

Meet Frequently - Get on-going feedback and refine work.

Data Collection - Understand your population and your community's resources. Get a clear perspective of your community; educate yourself.

Strength in Diversity - Assemble a variety of people, organizations, skills, and talents. Understand regional differences that affect your efforts.

Don't Stop! - Community processes are hard work. Use your process to submit applications for other funding sources and to advocate for your community's needs.

Part 2: Your Community's System -
Delivering Housing and Services

Good inclusive and comprehensive planning processes should lead to good local Continuum of Care systems. A careful balance of emergency, transitional and permanent housing, and services must be in place to help homeless people make the transition from the streets to jobs and independent living. Lansing, Michigan's Continuum of Care system is illustrative of one approach that works.

The Greater Lansing Homeless Resolution Network, the coordinating entity for the area, recognized early on that it lacked a mechanism to collaboratively identify and respond to each consumer's need once the person came to the attention of a particular agency. Providers "co-existed" in the community, with some information sharing, however, there was little opportunity to coordinate case planning and thereby recognize duplication in the services delivered. Outreach to the various subpopulations was done by staff in accordance with their own agency's strategy. Likewise, intake and assessment were functions of each provider working separately. Caseworkers assess a person's needs and provide in-house services or make referrals to other known agencies. As a result, Lansing has a large number of chronically homeless people because they disengage from services and remain unhoused rather than progressing through emergency, transitional, and permanent housing.

To eliminate this problem, the Network has begun designing a system that has coordinated outreach focused by sub-population, multiple in-take sites, a comprehensive assessment methodology, and case management services.

Data on each client will be computerized at each intake site and collected at the American Red Cross Center using the Automated National Client-specific Homeless services Recording (ANCHoR) system. Any homeless person identified through ANCHoR who repeatedly disengages from the services would have a comprehensive assessment and care plan developed by specialized case managers. As part of the plan, a case manager would convene a "wraparound team" of people who know the client through the community and/or through agency contact. The primary reason for using this approach is to further coordination and shared responsibility in hard service cases.

While Melanie Winnicker, Contract Manager, Human Relations and Services Department, City of Lansing readily admits that identifying the numbers of actual homeless people in the area for the gaps analysis was a major challenge, she indicated that having a good group of people, the Network, to work with was a real asset. The group was immediately able to break down the areas of "turfism" and move toward the common goal. According to Winnicker, the City of Lansing is enriched with services, however, they needed to look at coordinated case management and extended services as a group in order to be successful. Winnicker said that it was important for them to look at the big picture. Funds and outreach were going in different directions and as a group they reached a consensus to house these services in one place and funding that project.

The Network's goal is to increase awareness of this approach through increased interagency training and staff development. Also key to their system is Housing Resource Center staff who would interact regularly with the case managers and help place clients in the appropriate housing setting. The Resource Center would monitor available housing options through contacts with the Lansing Housing Commission, area

landlords, and other housing providers. Training, networking, and information sharing will also be key to more coordinated outreach.

Lessons Learned - The System

What's key to a good Continuum of Care system? There are Five C's to be learned from Lansing and Idaho:

Components - Components should reflect local needs and the diversity of your homeless population. Focus on all components, with special attention to those parts that need the most work and that greatly affect all of the others. Develop a system that serves all subpopulations.

Create Multiple In-take Points - Homeless people can be found in all settings. Have multiple in-take points to reach all persons.

Coordinate Housing and Service Delivery - Talk to other providers, network and train. Information sharing is key to eliminate duplication.

Case Management - Helps facilitate movement through the components. Keeps persons housed and engaged in services. Develop individualized case plans, and provide follow-up.

Clients - Know your consumers. Collect and update data and develop tracking systems.

With an average population density in 1990 of about 12 people per square mile, the State of Idaho had a unique challenge in developing its Continuum of Care system.

Early on, the Idaho Housing and Finance Association (IHFA), a state-wide nonprofit organization, took the lead in developing a state-wide homelessness strategy under which seven regional continuum of care delivery systems are being developed. Some of regions are further along in their systems' development, however, each has some components in place.

Like the Commonwealth of Kentucky, Idaho had to consider unique regional differences in available resources, economic conditions, and population distribution in its strategy. A major goal of its strategy is to curb migration of homeless people from the state's population centers.

To achieve this goal, IHFA identified homelessness prevention as a key part to its delivery systems since it reduces migration by stabilizing families and communities which can serve as a homeless person's support system. IHFA seeks to enhance prevention programs by requiring individualized assessments as a part of all prevention programs to identify the issues that put families and individuals at risk of homelessness--a large step beyond the traditional prevention approach of one-time rental or utility assistance payments. Integrated case management, improved transportation, and a standardized and centralized intake are also important parts of their developing Continuum of Care system

Part 3: Gaps and Priorities

One of the major goals of the Continuum of Care process is to avoid unnecessary duplication to focus precious resources to priority gaps in a community's system. The Maryland Rural Consortium, composed of seven primarily rural jurisdictions serving nine counties, is reaching this goal. Under the umbrella of the State Homeless Services Program created by the Maryland General Assembly in 1984, the counties have developed a single, multi-jurisdictional Continuum of Care system by examining their existing inventory, and identifying common gaps and priorities.

The State Homeless Program works closely with the Governor's Advisory Board in understanding and identifying the depth of homelessness and homeless person's needs. In 1986, Where Do We Go From Nowhere? was published articulating the problem and recommending specific action steps that have been updated and further refined over the years. Statistical information is collected on the state's current

inventory of housing and services on-going with Maryland's Consolidated Plan, annual studies and provider input on the number of homeless persons turned away on a given night, as key data sources.

In planning for the 1996 competition, each jurisdiction within the Consortium had input as to their area's need, and gaps in housing and supportive services. Homeless persons and community leaders were surveyed to get their input as well. Working groups reached a consensus on the degree of need and discussed the commonalities among the top three priority gaps that were identified by each county. They ranked their county's need using a high, medium, and low scale. Using one vote per jurisdiction, the gaps analysis chart was completed for the entire consortium. Transitional housing for families with children, chronic substance abusers and the general homeless population were assigned high relative priorities.

With gaps now identified, eligible organizations within the consortium communities were invited to submit projects for Supportive Housing, Shelter Plus Care and Mod Rehab SRO programs. A diverse panel representing nonprofits, government agencies, formerly homeless persons and others received 11 project applications all for the Supportive Housing Program. The projects were read and scored using criteria such as fit with priority gaps, applicant experience, project quality and the project's ability to leverage resources.

Lessons Learned - Gaps and Priorities

How does my community identify gaps in its delivery system? How do I best focus my resources?

Data, Data, Data - Let your data point the way. Use the Consolidated Plan, provider input and other reliable sources. Undertake annual surveys. Learn what you currently have and what you still need.

Prioritize Your Gaps - Stay focused. Work to make those tough decisions as to your community's current top needs.

Projects - Develop projects that fit the top gaps.

Be Fair! - Use a rational process that's inclusive in selecting projects to fill the gaps. Use generally accepted criteria and other means to select the best projects for your community's application.

Part 4: Supplemental Resources

Applicants must identify and obtain additional resources to help support projects and fill other gaps in their community's continuum of care system.

Anchorage, Alaska was able to leverage approximately $3 million with firm written agreements in place at time of application for half of its resources. Memoranda of Intent have been negotiated with the Cook Inlet Tribal Council, the Municipality of Anchorage, the Salvation Army and other organizations. Cash for acquisition and rehabilitation, operating costs, case management, emergency food and other costs will be brought to Anchorage's projects.

Anchorage was fairly lucky in acquiring commitments for resources for their Continuum of Care system. Jeanine Kennedy, Executive Director, Rural Alaska Community Action Program explains that they were successful in leveraging resources because the problem was especially evident in this rural population and their was a general commitment by those in the municipality of Alaska to provide housing and supportive services to the Native Alaskans that were in need. Once the people gathered for the meetings as outlined in the community process, it was easy, says Kennedy, to gain written agreements from participants. Participants were asked what role they wanted to play and they were assigned that responsibility. There was an eagerness and interest to help and to succeed.

Helpful Hint . . .

Involve key resources early.Developing the necessary resources is greatly facilitated if some of the participants in C-of-C meetings are affiliated with the resources needed.

Houston/Harris County, Texas has leveraged close to $32 million to help support its projects with substance abuse treatment, staff time, cash, food, building space and other items. Funds earmarked from the City of Houston's and Harris County's Community Development Block Grant (CDBG), HOME and other HUD resources will also be used.

Lessons Learned - Resources

Obtaining additional resources requires:

Partnership Building - Get to know your potential sources.

Creativity - Contact the sources you know, but also branch out to others. Think of Federal, state and local governments, private foundations, businesses and other organizations. Use mainstream and other programs.

Written Agreement - Get it in writing. Letters, memorandums of understanding and other forms that demonstrate a level of commitment.

In Summary - The Will to Do

While the magnitude of the problem may vary in each jurisdiction and approaches to resolving the problem may differ, each has in common a general commitment to resolving the problem and a mind-set to achieve the goal by working in partnership with others. Working together, entire communities can make a difference and give hope to those who so desperately need assistance. Stay tuned for the next round of the Homeless Assistance Competition.

For Further Information . . .

To find out more about Continuum of Care in Action, please contact your local HUD field office or SNAPS at (202) 708-4300. Spotlighting What Works is published three times each month by CPD's Office of Executive Services. This issue was written by Kathryn A. Pearson-West in collaboration with Cynthia Hernan. If you have a helpful tool, practice, or strategy to share, please contact Best Practices Project Manager, Letha Strothers, either by cc-mail or by calling her directly at 202-708-1283. All of us can benefit from your experiences!